Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

Handout 36

July 23, 2004

BCSS-C-04-019
BCSS-P-04-015
BCSS-ADM-04-005

MEMORANDUM

TO: Contracted and Non-Contracted Case Management Agencies
Direct Service Provider Agencies
BCSS Regional Offices

FROM: Barbara C. Dodge,
Director

RE: Clarification of Documentation Procedures

This will serve to clarify proper documentation procedures for staff to use in recording activities for recipients of waiver services.

Documentation in case records provides an ongoing "picture" of the progress toward achieving outcomes and the basis for decisions and recommendations for supportive services. For this reason, documentation of activities is not linked to minute increments, but rather describes the activity over a period of time.

While HIPAA requires billing to be recorded in 15-minute increments, this is not necessarily a requirement of documentation. Unless the activity only takes 15 minutes, such as administration of medication, then documentation would cover the period of time the activity took place. Documentation must be completed at the end of each shift for each service delivered.

An example of an adequate progress note would be a shopping trip with the direct support worker to the mall that occurs over a 3 hour time period, where the time is documented in a summary. Staff **would not** be required to document every 15 minutes to describe the ongoing activities. The adequate progress note could be done in a summary, describing the time the person left for the shopping trip, who accompanied them, possibly purchases made, a meal or snack eaten, a movie that was attended, the time they returned home and progress toward their personal outcome. Remember, however, that critical incidents, per BCSS policy, must always be included as a part of documentation.

Documentation is not intended to be intrusive or an embarrassment to anyone. It should describe the quality and quantity of services rendered, as well as provide accountability for the agency.

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September 22, 2004

BCSS-ADM-04-006
BCSS-C-04-021
BCSS-P-04-018

TO: **All Medicaid Home and Community-Based (HCB) Waiver Direct Service Providers**

FROM: **Barbara C. Dodge, MA FAAMR**
Director

RE: **Clarification of requirements for HCB Waiver Direct Service Providers regarding Individualized Back Up Plans and Emergency Evacuation Response Plans**

This memo will serve as clarification of requirements for Medicaid HCB Waiver Direct Service Providers regarding Individualized Back Up Plans and Emergency Evacuation Response Plans. HCB Waiver Direct Service Providers are required to have functional Individualized Back Up Plans and Emergency Evacuation Response Plans that are consistent with the participant's Comprehensive Plan of Care (CPOC).

HCB Waiver Direct Service Provider agencies shall possess the capacity to provide the support and services required by the participant in order to insure the participant's health and safety outlined in the approved CPOC.

For people with disabilities who need some form of assistance to accomplish life's daily tasks, being without the personal assistance and supports they need can be a frightening and intimidating experience. Without the necessary assistance and supports, the participant's physical and/or emotional health and safety can be negatively impacted. Even worse, the participant may experience loss of dignity, independence and control over his/her life and services. Well thought out backup plans that are prepared before such occasions arise, are not only required, but are essential to the overall well-being, safety and peace of mind of the participant.

Backup plans cover situations that may occur from time to time when direct support workers are absent, unavailable or unable to work for any reason. The participant's Support Coordinator (Case Manager), through a person-centered process, is responsible for working with the participant, his/her family, friends and providers during initial and subsequent annual CPOC planning meetings to establish plans to address these situations. Backup plans must be updated

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annually, or more frequently as needed, to assure information is kept current and applicable to the participant's needs at all times.

The Support Coordinator shall assist the participant and his/her circle of support to identify individuals who are willing and able to provide a backup system during times when paid supports are not scheduled on the participant's CPOC. When supports are scheduled to be provided by the direct service provider, providers must have back up systems in Place. It is unacceptable for the Direct Service Provider to use the participant's informal support system (i.e., friends and family) as a means of meeting the agency's individualized backup plan, and/or emergency evaluation response plan requirements. Families and others identified in the participant's circle of support may elect to provide back up but this does not exempt the provider from the requirement of providing the necessary staff for back up purposes.

The backup plan must include detailed strategies and person-specific information that addresses the kind of specialized care and supports needed by the participant, as specified in their individualized Comprehensive Plan Of Care (CPOC).

The agency must have in place policies and procedures that outline the protocols the agency has established to assure that backup direct support staff are readily available, that lines of communication and chain-of-command have been established, and that procedures for dissemination of the backup plan information to participants and Support Coordinators are in place. Protocols outlining how and when direct support staff are to be trained in the care and supports needed by the participant must also be included. Note: Training for workers must occur **prior** to the worker being solely responsible for the support of the participant.

Next, an Emergency Evacuation Response Plan must be developed and included in the participant's CPOC. An Emergency Evacuation Response Plan provides detailed information for responding to potential emergency situations such as fires, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and terrorist acts. The Emergency Evacuation Response Plan must include at a minimum the following components:

- Individualized risk assessment of potential health emergencies, geographical and natural disaster emergencies, as well as potential for any other emergency conditions;

- A detailed plan to address participant's individualized evacuation needs, including a review of individualized backup plans;

- Policies and procedures outlining the agency's protocols regarding implementation of Emergency Evacuation Response Plans and how these plans are coordinated with the local Office of Emergency Preparedness and Homeland Security, establishment of effective lines of communication and chain-of-command, and procedures for dissemination of Emergency Response Plan to participants and Support Coordinators; and

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- Protocols outlining how and when direct support staff and participants are to be trained in Emergency Evacuation Response Plan implementation and post emergency protocols. Note: Training for direct support staff must occur **prior** to worker being solely responsible for the support of the participant and participants must be provided with regular, planned opportunities to practice the Emergency Evacuation Response Plan.

Due to the requirements of HCBS Waivers to ensure the health and welfare of Waiver participants, Direct Service Providers who are deemed to be out of compliance in the provision of necessary supports will be removed from the Freedom of Choice listing and /or sanctioned up to and including exclusion from the Medicaid Program.

CC: All Case Management (Support Coordination) Agencies
BCSS Regional Offices
BCSS State Office Staff
All Policy and Procedure and Service Manuals

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

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October 12, 2004 **BCSS-P-04-019**

PROVIDER NOTICE

TO: Providers of Medicaid Waivers

FROM: Barbara C. Dodge, MA FAAMR
Director

RE: Policy Change and Clarification regarding Direct Service Provider Changes

Only the waiver participant can request a provider change. This request is facilitated through their support coordinator (case manager).

The following policy clarification and implementation is being given to all waiver providers:

I. Waiver Service Provider Changes

NOW and Children's Choice Provider changes for "good cause" require review by the Regional Manager who will make a "good cause" determination as defined in the respective waiver policies. If it is deemed approvable, the Regional Manager will sign and forward to the Contracted Agent for Prior Authorization. The Regional Manager will also submit a monthly report to the BCSS Provider Enrollment Manager. This monthly report will list any instances of "good cause" in which the provider has not rendered satisfactory services to the participant and will be used for re-enrollment policy adherence.

The **Elderly and Disabled Adult Waiver** policy is hereby amended to specify that provider changes may occur:

> Once every services authorization quarter (3 months) with the effective date being the beginning of the following quarter (January, April, July, or October). The request must be received to the BCSS Regional Office at least 30 days prior to the beginning of the Service Authorization Quarter.

The only exception to the above is for "good cause". In this case a "good cause" determination is made by the BCSS Regional Manager as described above. Good cause in the EDA waiver is defined as:

> The participant moves to a new region; or,
> The participant and direct service provider agency have unresolved difficulties and mutually agree to a transfer;
> Safety, health, and welfare have been compromised and/or the direct service provider has not rendered satisfactory services to the participant.

All waiver provider changes which are requested in the middle of a quarter (for good cause) must have an attached CPOC Balance Report and documentation from the old provider stating what services are expected to be used prior to the transfer; this must be approved by the family.

Copy: Support Coordination Agencies

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
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October 13, 2004 BCSS-P-0-020

MEMORANDUM

TO: Waiver Service Providers

FROM: Barbara C. Dodge

RE: Provider Number

In order to avoid delays and ensure proper payment for waiver services, providers shall be required to furnish a copy of their Provider Number Letter to the Support Coordinator with each signed agreement to provide services (CPOC or Revision).

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
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October 11, 2004 **BCSS-P-04-022**

TO: EDA Waiver Providers
NOW Waiver Providers
Children's Choice Waiver Providers

FROM: Barbara C. Dodge, MA FAAMR
Director

RE: Release of Authorization for Payment

It has come to our attention that many of you are billing for services that have been authorized, but **have not** been documented in the LAST as having been provided to the waiver participant. LAST data entry is a requirement of all waiver programs for all waiver providers. The LAST system will only release the amount of services your agency has actually provided and documented, that do not exceed the authorized amount based on the BCSS approved plan of care. Once the amount of services provided to each participant is entered by the Agency, that amount of services is then released to Unisys as reimbursable up to the amount authorized, based on the approved plan of care. Payment for only those services actually provided, appropriately documented based on programmatic requirements, and not exceeding the authorized amount shall be reimbursed.

Policy requirements and training were provided to each agency through Statistical Resources, Inc. (SRI). If you need another copy of the training packet, you may access it on the BCSS website at http://www.dhh.la.gov/bcss. If you need to know the representative from your agency who attended the required training, you may contact SRI.

As another resource, Statistical Resources conducts training every two weeks on this system. Anyone wishing to attend may contact SRI to schedule another training date.

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
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November 29, 2004

BCSS-C-04-027
BCSS-P-04-027
BCSS-ADM-04-011

MEMORANDUM

To: Contracted Support Coordinators
Medicaid Enrolled Direct Service Providers

From: Sue Merrill
Acting Director, BCSS

Re: Release of Documents When Changing Direct Service Providers

The Bureau of Community Supports and Services (BCSS) has reviewed the current New Opportunities Waiver (NOW) policy regarding the documents obtained by the support coordination agency when assisting a person in changing direct service providers.

According to Chapter 32, New Opportunity Waiver Manual, January 1, 2004, pages 14 and 15, the support coordinator is responsible in assisting the participant (recipient) to change direct service providers. One responsibility is to "Obtain the case record from the releasing provider which includes the most current six months of progress notes; time sheets**,** written documentation of the services provided..."

Effective immediately, the support coordinator will only be responsible for obtaining the last two (2) months of progress notes and **will not obtain any time sheets** from the releasing provider. The progress notes allow the new provider a glimpse of the activities of the person they are staffing.

Please accept this as the official notice that support coordinators are not required to obtain any time sheets from the releasing direct service provider when a person requests a change of service providers in the NOW Waiver.

C: Barbara Dodge
Randy Baumgartner
Jean Melanson
Loida Kellgren
Delphine Jackson
Stella Leigh
All BCSS Regional Managers

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§438.2. Illegal remuneration

A. No person shall solicit, receive, offer, or pay any remuneration, including but not limited to kickbacks, bribes, rebates, or bed hold payments, directly or indirectly, overtly or covertly, in cash or in kind, for the following:

(1) In return for referring an individual to a health care provider, or for referring an individual to another person for the purpose of referring an individual to a health care provider, for the furnishing or arranging to furnish any good, supply, or service for which payment may be made, in whole or in part, under the medical assistance programs.

(2) In return for purchasing, leasing, or ordering, or for arranging for or recommending purchasing, leasing, or ordering, any good, supply, or service, or facility for which payment may be made, in whole or in part, under the medical assistance programs.

(3) To a recipient of goods, services, or supplies, or his representative, for which payment may be made, in whole or in part, under the medical assistance programs.

(4) To obtain a recipient list, number, name, or any other identifying information.

B. An action brought pursuant to the provisions of this Section shall be instituted within one year of when the department knew that the prohibited conduct occurred. Such prohibited conduct shall be referred to in this Part as "illegal remuneration".

C. By rules and regulations promulgated in accordance with the Administrative Procedure Act, the secretary may provide for additional "safe harbor" exceptions to which the provisions of this Section shall not apply.

D. The following are "safe harbor" exceptions to which the provisions of this Section shall not apply:

(1) A discount or other reduction in price obtained by a health care provider under the medical assistance programs if the reduction in price is properly disclosed to the department and is reflected in the claim made by the health care provider.

(2) Any amount paid by an employer to an employee, who has a bona fide employment relationship with such employer, for the provision of covered goods, services, or supplies.

(3) Any discount amount paid by a vendor of goods, services, or supplies to a person authorized to act as a purchasing agent for a group of health care providers who are furnishing goods, services, or supplies paid or reimbursed under the medical assistance programs provided the following criteria are met:

(a) The person acting as the purchasing agent has a written contract with each health care provider specifying the amount to be paid to the purchasing agent, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such health care provider under the contract, or a combination of both.

(b) The health care provider discloses the information contained in the required written contract to the secretary in such form or manner as required under rules and regulations promulgated by the secretary in accordance with the Administrative Procedure Act.

(4) Any other "safe harbor" exception created by federal or state law or by rule.

Acts 1997, No. 1373, §1.

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Who is SRI?

What do they do?

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Statistical Resources, Inc. (SRI) is contracted by BCSS to:

- Prior Authorize (PA) direct services that have been approved by the BCSS regional office for all waiver services.
- Develop and maintain the Louisiana Service Tracking Software (LAST)
- Provide LAST software training and technical support to Direct Service Providers

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How are PA's issued?

- BCSS Regional Office sends approved Comprehensive Plan of Care (CPOC) information to SRI.
- PA's are issued based on the approved CPOC budget.
- PA's begin on the Payment Vendor Date.

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- PA's for Environmental Accessibility Adaptation (Environmental Modifications), and/or for Specialized Medical Equipment and Supplies (Assistive Devices) are issued for the CPOC year and are adjusted to reflect the completion date only after **Job Completion Form** is received from BCSS regional office.

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- PA's are issued in quarterly segments.
- PA's are issued for the entire CPOC Year at one time.
- PA's are electronically shipped to Service Provider Agency via LAST data system.

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How does PA's for the Children's Choice Waiver differ?

- PA's are issued with a cap based on the CPOC budget for the year.
- PA's for family training are issued for the CPOC year and are adjusted only after receipts documenting that the training was attended have been submitted and received.
- PA's for diapers are issued in monthly segments.
- All administrative fees are added by the LAST software.

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Louisiana Service Tracking Software (LAST)

- All service events, modification completion logs, and distribution of diapers logs must be entered into the LAST system.
- Information files must be sent to SRI prior to billing. Units of service are released based upon the data entered and received from your agency.

- LAST software, training, and technical support is provided by SRI to Direct Service Providers.
- LAST software has incorporated numerous reports to assist you with the service management, including balances remaining to be provided for a participant.

LAST Computer Specifications

- IBM compatible PC with a Pentium 4, Celeron or Equivalent Processor
- 1.44 MB 3.5 inch disk drive
- 512 MB RAM
- 25 MB free hard drive space
- Color monitor
- Printer
- DSL or Cable Modem and Broad Band Connection
- CD ROM
- Windows 2000, XP, or later version of operating system
- Internet account with E-mail and Web-browser software

What's Next?

- Once you have received your Medicaid Provider Numbers from Provider Enrollment and your first approved CPOC for a participant, **call Anita Nixon at SRI** to enroll in the next available software training class.
- SRI's phone number is: **(225)767-0501**

Who to call at SRI

Dr. Steven Buco, President

Request for Services and Prior Authorization Manager
– Roxanne Myers

Prior Authorization Supervisor
– Lakeisha Jarrett

LAST Training and Technical Support
– Anita Nixon

Statistical Resources, Inc.
11505 Perkins Road
Suite H
Baton Rouge, LA 70810

(225)767-0501
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